## Attachment A: Directory of Submitted Desk Review Documents and Crosswalk to the Phase One Readiness Review Criteria

As noted in the letter above, we ask that your ICDS Plan provide specific information to the review team related to your ICDS Plan's submitted documents. Column 1 of the table below list all of the criteria that will be used to assess readiness during the desk review. Column 2 of the table provides examples of the types of evidence that your ICDS Plan may submit to demonstrate that your ICDS Plan has met the given criteria.

Please complete column 3 (File/Document Name and Page Numbers/Sections) of the table below. **Please submit the table to the secure website by October 22, 2013.** When completing the table, please note the following:

- In column 2, please provide the **names of the files/documents that you will be submitting** to provide evidence that your ICDS Plan meets the corresponding criteria. Next to the file/document name**, please provide the relevant page numbers/sections** of the file/document in parenthesis (see tables below for examples).
- In all instances, please ensure that all documents are numbered, and the page number you list is the **page number of the actual document (and that will print on the document)**, as opposed to the page number of the .pdf or other file format.
- You may list more than one file/document for each criterion; however please ensure that the page numbers/sections are provided in parenthesis next to each file/document's name.
- You may also list the same file/document for multiple criteria; however, please ensure that the correct page numbers/sections for the given criteria are provided in parenthesis next to the file/document's name each time it is listed.
- Please use the same naming convention for all files/documents that you list. This convention should include the ICDS Plan's name, a concise name of the file/document that clearly defines what the document is, and the date that you upload the file (see tables below for examples).
- Please ensure that all files/documents that you list in the tables are named consistently with the actual files/documents that you upload to the secure website (specific instructions for uploading the listed files/documents to the secure website are provided in Attachment C).
- Please ensure that nothing that you share with the review team includes protected health information (PHI).
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| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| **Assessment Processes** | | |
| **A. Transition to New ICDS Plan and Transition of Care** | | |
| 101. The ICDS Plan ensures continuity of care for enrollees transitioning from Medicaid by maintaining current providers and service levels at the time of enrollment according to the following transition requirements:<br><br>a. Physicians: the ICDS Plan must provide a 90 day transition period for enrollees identified for high risk care and 365 days for all others; | Transition of care plan or policies and procedures includes these provisions. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| b. Durable Medical Equipment (DME): the ICDS Plan must honor prior approvals for items not yet delivered and must review ongoing prior authorizations for medical necessity;<br>c. Scheduled Surgeries, Organ, Bone Marrow, Hematopoietic Stem Cell Transplant: the ICDS Plan must maintain providers specified in prior authorizations;<br>d. Chemotherapy/Radiation: the ICDS Plan must authorize treatment initiated prior to enrollment through the course of treatment with the provider specified in the existing prior authorization;<br>e. Dialysis Treatment: the ICDS Plan must provide 90 days with the same provider and level of service; before transition, the Individualized Care Plan documents successful transition planning to new provider;<br>f. Vision and Dental: the ICDS Plan must honor prior authorizations when the item or service has not been delivered;<br>g. Medicaid Home Health and Private Duty Nursing:<br>i. For HCBS waiver enrollees, the ICDS Plan must maintain the existing service, at the level the enrollee is receiving at the time of enrollment, with the current providers at the current Medicaid rate for 365 days unless:<br>a) A significant change, as defined in OAC 5101:3-45-01, occurs; or<br>b) The enrollee expresses a desire to self-direct services;<br>ii. For enrollees who are not in the HCBS waiver, and for those on waiver using the Assisted Living Service, the ICDS Plan must continue existing providers at the current service level for 90 days and then review for medical necessity after an in-person assessment that includes observation of the service delivery;<br>h. Assisted Living Waiver Service and Medicaid Nursing Facility Services: for enrollees who were in the Assisted Living Waiver or who reside in a nursing facility at the time of enrollment, the ICDS Plan must maintain the current provider at the current rate for the duration of the Demonstration;<br>i. Direct Care Waiver Services: the ICDS Plan must maintain service at the current level for 365 days and with the current providers at the Medicaid rate; The ICDS Plan may change the service provider only after an in-home assessment is completed and a plan for transition to a new provider is in place.<br>j. Other Waiver Services: the ICDS Plan must maintain the service at the current level for 365 days and the existing service provider at the existing rate for 90 days. The ICDS Plan may change the service provider only after an in-home assessment is completed and a plan for transition to a new provider is in place; and<br>k. Medicaid Community Behavioral Health: the ICDS Plan must maintain the current provider | | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| at the Medicaid rate and the current level of services for 365 days. | | |
| 102. During the transition period, the ICDS Plan may change an existing provider only under the following circumstances:<br><br>a. The enrollee requests a change;<br>b. The provider chooses to discontinue providing services to an enrollee (as currently allowed by Medicare or Medicaid); or<br>c. The ICDS Plan, CMS, or the state identifies provider performance issues that affect an enrollee's health and welfare. | Continuity of care plan or policies and procedures includes these provisions. | |
| 103. The ICDS Plan assures that, within the first 90 days of coverage, it will provide a temporary supply of drugs 1) when the enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug or 2) when the drug is one that the state is requiring the ICDS Plan to cover under the Demonstration. | P&P allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on re-fills of non-formulary drugs that otherwise meet the definition of a Part D drug and drugs that the state is requiring the ICDS Plan to cover under the Demonstration. | |
| 104. The ICDS Plan assures that, in outpatient settings, temporary fills of non-formulary drugs that 1) otherwise meet the definition of a Part D drug, and 2) the state is requiring the ICDS Plan to cover under the Demonstration, contain at least a 30-day supply; multiple fills up to a cumulative 30 days supply are allowed to accommodate fills for amounts less than prescribed, anytime during the first 90 days of a enrollee's enrollment in a plan, beginning on the enrollee's effective date of coverage" | Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days. | |
| 105. The ICDS Plan assures that, in long-term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug, as well as Medicaid-covered drugs, contain at least a 91-day supply, unless a lesser amount is requested by the prescriber. | Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days. | |
| 106. The ICDS Plan provides written notice to each enrollee, within 3 business days after the temporary fill if his or her prescription is for a Part D or Medicaid drug that:: | Transition plan P&P defines a time period (within 3 business days) when it must provide enrollees with notice | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| a. Is not on the Plan's formulary; or<br>b. Is on the Plan's formulary, but requires prior authorization under the Plan's utilization management rules. | about temporary fills and their ability to file an exception or consult with prescriber to find alternative equivalent drugs on the formulary. | |
| 107. The ICDS Plan has staff designated to contact enrollees during the 90-day transition period to assist them in understanding their options when they refill a prescription for a Part D or Medicaid drug that:<br>a. Is not on the Plan's formulary; or<br>b. Is on the Plan's formulary, but requires prior authorization under the Plan's utilization management rules. | Transition plan P&P states that the ICDS Plan has staff available to contact enrollees when they refill a non-formulary drug or receive a non-covered service during the 90 day transition period. | |
| **B. Assessment** | | |
| 108. The ICDS plan develops an identification strategy:<br>a. That uses a combination of:<br>i. Predictive modeling software;<br>ii. Health risk assessment tools;<br>iii. Functional assessments;<br>iv. Referrals from individuals, family members and providers; and<br>v. Administrative claims data.<br>b. Where results are used to assign an initial risk stratification level for the purposes of determining the mode and timeframe for completing the assessment. | The Risk Stratification, New Enrollee, or another relevant P&P includes the Plan's strategy for identifying Enrollee's initial risk stratification level | |
| 109. The ICDS plan must develop a risk stratification framework that:<br>a. Is used to target interventions and allocate resources based on individual needs.<br>b. Consists of at least three stratification levels that meet the following requirements:<br>i. The highest tier must meet or exceed the contact schedule standards for ODM's intensive level;<br>ii. The middle tier must meet or exceed the contact schedule standards for ODM's medium level; and<br>iii. The lowest tier must meet or exceed the contact schedule standards | The plan submits policies or other documentation that includes a risk stratification framework that articulates the stratification level and the contact schedule. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| for ODM's monitoring level. | | |
| 110. The ICDS plan must develop criteria and thresholds for each risk stratification level that will be used to determine how an individual is assigned to a risk stratification level. | The Plan's risk stratification P&Ps or risk stratification framework articulates the criteria and the thresholds for each risk stratification level. | |
| 111. The ICDS plan must consider the following factors when determining the assignment of an enrollee to a stratification level:<br>a. Duration of HCBS waiver enrollment;<br>b. Current waiver acuity level;<br>c. Change in existing care manager relationship;<br>d. Change in caregiver status/support;<br>e. Presence and severity of chronic conditions;<br>f. Polypharmacy<br>g. Nursing facility or assisted living facility placement;<br>h. Functional and/or cognitive deficits;<br>i. Risk factors for being institutionalized;<br>j. Historical inpatient or emergency department utilization;<br>k. Residential/housing status;<br>l. Gaps in care; and<br>m. Intact support system. | The Plan's risk stratification P&Ps or risk stratification framework describes the factors in determining the assignment of an enrollee to a stratification level, which at a minimum, includes a-m. | |
| 112. The ICDS plan must: | The Care Planning P&P explains how | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| a. Use the results of the comprehensive assessment to confirm or modify the enrollee's assignment to a risk stratification level;<br>b. Communicate the risk level to the enrollee's trans-disciplinary care management team;<br>c. Continuously evaluate whether an enrollee's risk stratification level should be adjusted due to:<br>i. Changes in the individual's need(s); and<br>ii. Progress in meeting care plan goals and outcomes; and<br>d. If the ICDS Plan determines that an enrollee's risk stratification level should be adjusted:<br>i. Identify the reason(s) for changing the enrollee's risk stratification level;<br>ii. Discuss the proposed action with the enrollee and the trans-disciplinary care management team, as appropriate;<br>iii. Provide reasonable notice about the change in the risk level to the enrollee and the trans-disciplinary care management team; and<br>iv. Revise the communication plan for contact with the enrollee, if necessary. | the Plan meets these requirements. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| 113. The ICDS Plan will completes an initial comprehensive assessment for all enrollees according to the following timeframes:<br><br>a. Within 15 days of enrollment effective date for enrollees assigned to the intensive level;<br>b. Within 30 days of enrollment effective date for enrollees assigned to the high level;<br>c. Within 60 days of enrollment effective date for enrollees assigned to the medium level;<br>d. Within 75 days of enrollment effective date for enrollees assigned to the low or monitoring levels. | Assessment P&P outlines the process by which the ICDS Plan will administer the initial assessment and updates to the initial assessment. At a minimum, the process should include these requirements, but it should further outline the process for identifying, contacting, and conducting the assessment within the appropriate time frame for each enrollee. | |
| 114. The ICDS Plan will complete a reassessment of each enrollee within 365 days of the enrollee's initial comprehensive assessment completion date. | The Assessment P&P explains this requirement. | |
| 115. The ICDS Plan will complete initial comprehensive assessments and the annual reassessments at the enrollee's primary place of service (i.e., home or institutional facility) for enrollees:<br>a. Assigned to the intensive or high risk stratification levels; or<br>b. Receiving HCBS waiver services. | The Assessment P&P discusses when the comprehensive assessment and annual reassessments will be completed at the enrollee's home or institutional facility. | |
| 116. The ICDS Plan may complete initial comprehensive assessments and annual reassessments telephonically for enrollees assigned to the low, medium, or monitoring levels, unless an in-person assessment is requested by the enrollee, caregiver, or provider. | The Assessment P&P discusses when the comprehensive assessment and annual reassessments will be completed telephonically. | |
| 117. The ICDS Plan must have a policy and procedure for updating assessments that includes the following:<br>a. Assessments must be updated when:<br>i. There is a change in the enrollee's health status or needs;<br>ii. A change in diagnosis;<br>iii. A change in caregiver status;<br>iv. A change in functional status;<br>v. A significant health care event (e.g., hospital admission or transition between care settings); or<br>vi. As requested by the enrollee, caregiver, and/or provider; and<br>b. In determining whether to complete the update in-person or by telephone, the ICDS plan must consider: | The Plan's P&Ps outline the procedures for updating that meets the minimum standards in the criterion. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| i. Why the assessment needs to be updated;<br>ii. The enrollee's needs;<br>iii. The enrollee's health/functional status; and<br>iv. The enrollee's preference. | | |
| 118. Updates to the assessment must be reflected in:<br>a. The comprehensive care plan; and<br>b. For enrollees receiving waiver services, the waiver service plan as well. | Assessment P&P includes the requirement that updates to the assessment are reflected In the comprehensive assessment and the waiver service plan. | |
| 119. The ICDS Plan requires that:<br>a. The comprehensive assessment be completed by a member or members of the enrollee's trans-disciplinary care management team who:<br>i. Possess an appropriate professional scope of practice, licensure, and/or other credentials; and<br>ii. Is appropriate for responding to or managing the consumer's needs. | Assessment P&P outlines the process by which the ICDS Plan will administer the initial assessment. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| 120. The ICDS Plan will include at least the following domains in its comprehensive assessment tool:<br><br>a. Behavioral health needs;<br>b. Medical needs;<br>c. Functional and/or cognitive needs;<br>d. Social needs;<br>e. Long term services and supports;<br>f. Nutritional needs;<br>g. Medical and behavioral health history;<br>h. Activities of daily living and/or instrumental activities of daily living;<br>i. Self-care capabilities;<br>j. Health status;<br>k. Transitional or discharge plans;<br>l. The enrollee's strength and abilities, goals, preferences and desired level of involvement in the care planning process;<br>m. The enrollee's willingness/readiness to change behaviors;<br>n. Informal and formal supports;<br>o. Caregiver status and capabilities;<br>p. Health literacy;<br>q. Health, welfare and safety;<br>r. History, detection or suspicion of abuse, violence or trauma;<br>s. Environmental/residential assessment;<br>t. Spiritual;<br>u. Cultural;<br>v. Financial;<br>w. Special communication needs;<br>x. Transportation capabilities;<br>y. Advance care planning; and<br>z. Wellness and prevention activities. | ICDS plan must provide a of its sample assessment tool. The comprehensive assessment tool includes, at a minimum, the domains in the criterion. | |
| 121. In completing the assessment, the ICDS Plan will use information from:<br>a. The enrollee;<br>b. The enrollee's treating providers;<br>c. The enrollee's waiver coordinator (if applicable); | Assessment P&P outlines the process by which the ICDS Plan uses information and data from the sources required by the criterion. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| d. Family/caregivers;<br>e. The enrollee's medical records; and<br>f. Other relevant data sources. | | |
| 122. At the initial assessment by the ICDS Plan, the ICDS Plan provides enrollees seeking waiver enrollment an overview of:<br>a. The waiver program,<br>b. The role of the ICDS plan with respect to enrollees who are waiver participants; and<br>c. The care planning process. | Assessment P&P describes the information provided to enrollees seeking waiver enrollment. | |
| **Care Management** | | |
| **A. ICDS Plan Care Management and Trans-Disciplinary Care Management Team (Care Team)** | | |
| 201. The ICDS Plan has a process for assigning an enrollee to a care manager with the appropriate experience and qualifications based on an enrollee's assigned risk level and individual needs (e.g. communication, cultural/linguistic competency, cognitive, or other barriers). | Care management P&P requires each enrollee to be assigned a care manager based on his or her risk level and/or individual needs and outlines the process for assigning such care manager.<br><br>ICDS Plan describes reasonable measures taken to ensure that staff and enrollees are matched based on their expertise and special needs. | |
| 202. The ICDS Plan has a process to ensure that an enrollee and/or caregiver are able to request a change in his or her care manager. | Care management P&P describes the process by which an enrollee may request a change in his or her care manager (as applicable). | |
| 203. The ICDS Plan will assure that:<br>a. Each enrollee has a trans-disciplinary care management team; and<br>b. The trans-disciplinary care management team:<br>i. Is led by a care manager who is responsible for ensuring the integration of the enrollee's medical, behavioral health, substance use, long-term services and supports (LTSS) and social needs; and<br>ii. Participates in and supports key care management functions, such as completion of the comprehensive assessment and developing, implementing, monitoring, and | ICDS Plan has P &P for the care management team functions and structure. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| updating the care plan, at the direction of the care manager. | | |
| 204. The members of the trans-disciplinary care management team will consist of:<br>a. The enrollee and/or the enrollee's authorized representative;<br>b. The primary care provider (PCP);<br>c. The care manager;<br>d. The 1915(c) waiver service coordinator, if applicable;<br>e. Specialists;<br>f. Anyone requested by the enrollee; and,<br>g. As appropriate, and the enrollee's family/caregiver/other supports. | ICDS Plan has P&P for the care management team functions and structure. | |
| 205. The ICDS care manager:<br>a. Will be the accountable point of contact for the enrollee; and<br>b. Will be responsible for functions that include, but are not limited to, the following:<br>i. Delineating the roles and responsibilities for all trans-disciplinary care management team members;<br>ii. Directing and delegating care management activities;<br>iii. Developing, implementing, monitoring, and updating the care plan; and<br>iv. Exchanging information between trans-disciplinary care management team members; and facilitating team meetings. | ICDS Plan has P&P for the care management team functions and structure. | |
| 206. The ICDS Plan is responsible for ensuring that staff who are perform care management functions:<br>a. Are operating within their professional scope of practice;<br>b. Are appropriate for responding to the enrollee's health needs; and<br>c. Comply with the state's licensure/credentialing requirements. | The staffing plan or other relevant P&P explain how the Plan ensures that staff performing care management functions meet the requirements of the criterion. | |
| **B. Comprehensive Care Plan & Waiver Service Plan** | | |
| 207. The enrollee's trans-disciplinary care management team, led by the enrollee's care manager, will develop an integrated, individualized care plan for the enrollee within 15 days of the initial comprehensive assessment. | Care planning P&P explains how trans-disciplinary care management team develops the care plan within 15 days of the initial comprehensive assessment. | |
| 208. The ICDS Plan must develop and implement a person-centered care planning process that:<br>a. Yields an integrated, individualized care plan for the enrollee; | Care planning P&P states that the ICDS Plan assures that these elements are incorporated into the plan of care. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| b. Is based on the recent comprehensive assessment; and<br>c. Includes the following elements:<br>i. Prioritized measureable goals, interventions, and anticipated outcomes;<br>ii. Completion timeframes for the measureable goals, interventions and anticipated outcomes that address the member's physical, behavioral, social and long term service and support needs<br>iii. Identification and prioritization of the individual's concerns, strengths, and preferences for care;<br>iv. A process to develop, update, and review the care plan with the enrollee, family/caregivers, caregivers, the primary care provider, other treating providers, and members of the trans-disciplinary care management team, as appropriate;<br>v. Identification of the providers responsible for delivering services;<br>vi. Identification of referrals made to specialists or providers and confirmation that the enrollee received the services;<br>vii. A provision that if the ICDS Plan determines that an enrollee needs a service provided by a community agency, the ICDS Plan will:<br>A. Refer the enrollee to a community services agency;<br>B. Assist the enrollee in contacting the agency; and<br>C. Validate that the enrollee received the service;<br>viii. A communication plan developed with the enrollee, including the method of preferred contact and a contact schedule that is based on the enrollee's needs; and<br>ix. Ongoing medication management with the goals of:<br>A. Increasing the enrollee's compliance with his/her medication regimen;<br>B. Avoiding adverse medication interactions and complication; and<br>C. Assuring reconciliation of medications at the point of discharge or transfer between care settings. | ICDS plan submits care plan template for review | |
| 209. The ICDS Plan will ensure that the enrollee receives:<br>a. Any necessary assistance and accommodations to prepare for, and fully participate in, the care planning process; and<br>b. Clear information about:<br>i. His or her health conditions and functional limitations;<br>ii. How family members and social supports can be involved in the care planning as the enrollee chooses; | Care planning P&P describes how the ICDS Plan will ensure that the enrollee receives necessary assistance and the types of information specified. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| iii. If applicable, self-directed care options and assistance available to self-direct care; and<br>iv. Available treatment options, supports and/or alternative courses of care. | | |
| 210. The ICDS Plan must revise the comprehensive care plan:<br>a. As expeditiously as the individual's needs warrant; and<br>b. No later than 14 calendar days from the date the change in need is identified. | The care planning P&P explains the requirements for when the Plan must revise the comprehensive care plan and the process for doing so. | |
| 211. In developing and implementing care plan goals and interventions, the ICDS Plan must apply evidence-based guidelines or best practices for care planning. | The care planning P&P describes the evidence-based guidelines or best practices it uses in developing and implementing care plan goals and interventions. | |
| 212. The ICDS Plan must have policies and procedures for ongoing monitoring of the care plan that describe how the Plan will:<br>a. Assess and document the enrollee's progress in achieving goals and outcomes established in the care plan;<br>b. Coordinate care and services for the enrollee with the waiver service coordinator, primary care provider, specialist(s), and other service providers/coordinators, as appropriate;<br>c. Identify:<br>i. Adherence to relevant evidence-based guidelines/practice;<br>ii. Transitions across care settings;<br>iii. Barriers to care;<br>iv. Appropriate service utilization;<br>v. Quality services; and<br>vi. Gaps in care; and<br>d. Timely revise the care plan based on identified gaps in care or when a change in health status or need is identified. | The Plan has P&Ps that outline the monitoring process describing how it complies with the requirements. | |
| 213. The ICDS Plan has a strategy to evaluate routinely the effectiveness and impact of the ICDS Plan's care management model with regard to:<br>a. Health outcomes;<br>b. Consumer satisfaction;<br>c. Quality of life of participating enrollees;<br>d. Independent living status; | The Plan has P&Ps describing how it will evaluate the care management model with regard to a-h. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| e. Functional status;<br>f. Inpatient hospital utilization rates;<br>g. Emergency department utilization rates; and<br>h. Medical costs. | | |
| 214. In evaluating its care management model, the ICDS Plan:<br>a. Evaluates the results for the overall program;<br>b. Evaluates the results by each stratification level;<br>c. Uses the results of the evaluation to make enhancements, as necessary, to the care management program; and<br>d. Makes the results of its evaluation available to ODM upon request. | The Plan's P&P on evaluating the care management model includes a process for evaluating the model in compliance with the criterion. | |
| 215. The ICDS plan has policies and procedures that include the following:<br>a. A strategy for educating the enrollee about the self-direction option;<br>b. A process for documenting the availability of self-directed services;<br>c. Identifying and implementing an assessment of the enrollee's ability and readiness to self-direct care and assume the responsibilities of an employer and/or budgeting for the delivery of services;<br>d. A strategy for educating members of the trans-disciplinary care management team about self-directed care;<br>e. A provision to refer consumer-employed providers to ODM and Plan provider agreement processes so that they can apply for a Medicaid provider agreement; and<br>f. A process to continuously evaluate the self-directed option for the enrollee;<br>g. A process to transition an enrollee to traditional waiver services, without disruption in care when self-direction has been voluntarily or involuntarily terminated. | The Plan's P&P on self-directed services outlines its strategy and process to meet the elements of this criterion. | |
| **D. Delivery of Care Management and Waiver Service Coordination** | | |
| 216. The ICDS Plan must establish a schedule for a member of the enrollee's trans-disciplinary care management team to contact the enrollee that is based on the enrollee's needs and facilitates ongoing communication with the enrollee. | The Plan's risk stratification framework or P&P on the trans-disciplinary care management team describes how the team establishes a schedule for contact with the enrollee based on the enrollee's need. | |
| 217. The ICDS plan has a policy that ensures that the contact schedule for each enrollee will reflect at a minimum the standards established by the State for each stratification level in the three-way contract. | The Plan's risk stratification framework or P&P on the trans-disciplinary care management team | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| | outlines the contact schedule for enrollees. | |
| 218. The ICDS Plan must document in the enrollee's care management record the following:<br>a. Contract schedules for the enrollee; and<br>b. Any exceptions to the contract schedule. | | |
| 219. Upon request, the ICDS Plan must provide a copy of the contact schedule to the enrollee. | The care management P&P (or other relevant documentation) articulates this requirement. | |
| 220. The ICDS Plan shall assure that:<br>a. At least one of the in-person visits within the first six months after enrollment is conducted at the location of the enrollee's primary place of service (i.e., home or institutional facility, unless an alternate location is requested by enrollee);<br>b. After the first six months, at least one in-person visit annually is conducted at the location of the enrollee's primary place of service, unless an alternate location is requested by the enrollee; and<br>c. Additional in-person visits occur at a location that is agreed upon by the enrollee and the ICDS Plan. | The care management P&P (or other relevant documentation) outlines how it assures that these requirements for in-person visits are met. | |
| 221. In-person visits may be conducted by any member of the trans-disciplinary care management team. | The care management P&P (or other relevant documentation) articulates this requirement. | |
| 222. The activity conducted during the in-person visit:<br>a. Must be linked to the goals, interventions, and outcomes identified in the care plan; and<br>b. Must be directed by the ICDS Plan care manager. | The care management P&P (or other relevant documentation) articulates these requirements. | |
| 223. The outcome of the in-person visit must be:<br>a. Documented;<br>b. Reported back to the ICDS Plan care manager; and<br>c. Integrated into the plan of care. | The care management P&P (or other relevant documentation) outlines these requirements. | |
| 224. For enrollees receiving HCBS waiver services, upon the discovery of a potential significant health care event, the care manager or the waiver service coordinator must:<br>a. Make telephone contact with the enrollee by the end of the next full calendar day after the significant change event; and<br>b. If it is determined through this telephone contact that a significant change has occurred, conduct a face-to-face visit with the enrollee by the end of the third full calendar day following discovery. | The P&P on HCBS waiver service coordination/planning describes the process and requirements of the waiver service coordinator upon the discovery of a potential significant health care event. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| 225. The ICDS plan, through the waiver service coordinator, will be responsible for:<br>a. Developing the waiver service plan with the individual;<br>b. Sharing the waiver service plan with the trans-disciplinary care management team for review and approval;<br>c. Coordinating the approved waiver services;<br>d. Assuring the individual's health, welfare and adequacy of service delivery; and<br>e. Integrating the waiver service plan into the comprehensive care plan. | The P&P on HCBS waiver service coordination/planning describes the responsibilities of the service coordinator. | |
| 226. Enrollees enrolled in the ICDS waiver program will be able to select a waiver service coordinator to facilitate and manage the delivery of waiver services. If an enrollee does not select a waiver service coordinator, one will be assigned to the enrollee. | The P&P on HCBS waiver service coordination/planning describes the process of informing the enrollee of his choice to select and waiver service coordinator and the process for assigning one to the enrollee if she does not select one. | |
| 227. The ICDS plan must allow individuals to exercise choice and control over:<br>a. The provision of waiver services they receive as determined during the waiver service planning process; and<br>b. The individuals who participate in the waiver service planning process. | The P&P on HCBS waiver service coordination/planning describes how the plan will meet these requirements. | |
| 228. The ICDS Plan ensures that services and supports furnished to enrollees receiving HCBS services are planned and implemented in accordance with each individual's needs and expressed preferences. | The P&P on HCBS waiver service coordination/planning describes how the plan will meet this requirement. | |
| 229. The ICDS plan must assist the individual with the development of a back-up plan that:<br>a. Provides for alternative arrangements for the delivery of services in the event that the responsible provider fails or is unable to deliver them;<br>b. Reflects both informal and formal services; and<br>c. Is incorporated into the individual's comprehensive care plan. | The P&P on HCBS waiver service coordination/planning describes how the plan will meet these requirements. | |
| 230. The ICDS plan must:<br>a. Review and approve the waiver service plan in accordance with coverage and authorization service requirements established at 42 CFR 438.210; and<br>b. After approving the waiver service plan and authorizing services, provide to the enrollee or his or her legally responsible person:<br>i. Notice of the approval; and<br>ii. Information about the services approved and the start date for those services;<br>iii. A copy of the waiver service plan. | The P&P on HCBS waiver service coordination/planning describes how the plan will meet these requirements. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| 231. The ICDS plan must have a policy and procedure for updating the waiver service plan which states that the ICDS Plan will:<br>a. Update the waiver service plan:<br>i. As appropriate based on the individual's assessed needs;<br>ii. When the ICDS plan becomes aware of any relevant information that should be included in the plan;<br>i. As appropriate, within 14 days of the following:<br>A. A significant change in the enrollee's health status or needs;<br>B. A significant health care event such as a hospital admission or a transition between care settings;<br>C. A change in the enrollee's functional status; and<br>D. Loss of a enrollee's caregiver;<br>iii. As soon as the need/issue is identified through the monitoring process; and<br>iv. As necessary to assure that the waiver service plan is updated when the comprehensive assessment and comprehensive care plan are updated;<br>b. Assure that any updates to the waiver service plan are communicated to the ICDS Plan care manager;<br>c. Assure that any updates to the service plan that are the result of changes to the comprehensive assessment are made as soon as the individual's needs warrant, but no later than 14 calendar days after identifying a change in the individual's needs or circumstances. | The P&P on HCBS waiver service coordination/planning describes how the plan will meet these requirements. | |
| 232. The ICDS plan must assure that the waiver service coordinator:<br>a. Monitors that:<br>i. The enrollee can exercise a free choice of providers from among the ICDS Plan's panel of providers;<br>ii. The services delivered meet the needs of the enrollee;<br>iii. The outcomes identified in the waiver service plan are appropriate;<br>iv. Methods are in place for prompt follow up and remediation of identified problems; and<br>v. Unmet needs and the outcomes of service delivery are reported to the ICDS Plan care manager and/or trans-disciplinary care management team; and<br>b. Reports to the ICDS plan care manager any relevant information gathered during the monitoring so that the comprehensive care plan can be updated accordingly. | The P&P on HCBS waiver service coordination/planning describes how the plan will meet these requirements. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| 233. For enrollees receiving waiver services, the ICDS plan must have the following in place to assure the health and safety of the enrollees:<br>a. Policies for reporting, investigating, and individual remediation of incidents;<br>b. Policies for the development of individual prevention plans specific to the enrollee; and<br>c. An incident management tracking systems. | The P&P on HCBS waiver service coordination/planning describes how the plan will meet these requirements. | |
| **E. Transitions Between Care Settings** | | |
| 234. The ICDS Plan has a strategy for managing transitions of care between care settings which includes:<br>a. Obtaining the discharge/transition plan;<br>b. Conducting timely follow up with the individual and his/her providers, as appropriate;<br>c. Performing medication reconciliation; and<br>d. Arranging for the timely provision of informal and formal supports, and<br>e. Ensuring the enrollee receives the services. | Care setting transitions P&P explains how the ICDS Plan manages the transition of care between care settings to meet the requirements of this criterion.<br><br>Sample care setting transition plan(s) detail the steps the ICDS Plan takes to ensure continuity of care for an enrollee changing care settings. | |
| 235. The ICDS Plan's protocols for care setting transition planning ensure that all community supports are in place prior to the enrollee's move and that providers are fully knowledgeable and prepared to support the enrollee, including interface and coordination with and among clinical services and LTSS. | Care setting transitions P&P explains how the ICDS Plan ensures that community supports are available prior to an enrollee's move.<br><br>Care setting transitions P&P explains how the ICDS Plan assesses the qualifications of those providers charged with caring for an enrollee after his or her move.<br><br>Sample care setting transition plan(s) detail the steps the ICDS Plan takes to ensure continuity of care for an enrollee changing care settings. | |
| **Enrollee and Provider Communications (continuation from Phase I)** | | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| 407. The ICDS Plan operates an enrollee services telephone line that is accessible nationwide via a toll-free number, and operates from 8:00 a.m. to 8:00 p.m., Monday through Friday, except major holidays. | Enrollee services telephone line P&P includes the requirements of the criterion. | |
| 408. The ICDS Plan operates a toll free care management support line twenty-four hour, seven days a week, that:<br>a. Is available nationwide;<br>b. Is staffed by appropriately trained and qualified health professionals who are able to:<br>i. Access the enrollee's records;<br>ii. Assess the enrollee's issues; and<br>iii. Provide an appropriate course of action. | The Plan has P&Ps or other documentation outlining the policies of its care management support line. | |
| 409. If the ICDS Plan identifies care management needs for an enrollee, the ICDS Plan ensures that the following occurs:<br>a. The staff person facilitating the resolution of the enrollee's issue has access to, and is familiar with, the enrollee's plan of care; and<br>b. The ICDS Plan provides timely and appropriate follow up, including the provision of in-person support if such support is warranted, to assure the enrollee's health, welfare and safety. | Enrollee communication P&P or other relevant documentation includes these documentation. | |
| 410. In order to respond to providers and enrollees seeking information related to coverage determinations and appeals, the ICDS Plan operates a toll-free call center that is:<br>a. Staffed by live customer service representatives; and<br>b. Operates during normal business hours and never less than 8:00 A.M. to 6:00 P.M., Monday through Friday according to the time zones for the regions in which the Plan operates. | Documentation on the coverage determination line complies with these requirements as well as those in the Medicare Marketing Guideline relevant to this section. | |
| 411. The ICDS Plan maintains a contract with a language line company that:<br>a. Provides interpreters for non-English speaking and limited English proficiency enrollees; and<br>b. Maintains hours of operation for the ICDS Plan's language line that are the same as the hours for the enrollee services telephone line. | Contract with language line company includes these requirements, including mandatory hours of operation. | |
| Enrollee Protections | | |
| **A. Appeals and Grievances** | | |
| 506. For ICDS waiver participants with limited literacy, the ICDS Plan provides a verbal explanation of grievances and appeal rights during the initial home visit. | The Grievance and Appeals P&P describes the process of when verbal explanations of grievances is | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| | completed. | |
| 507. The ICDS Plan provides enrollees with reasonable assistance in filing appeals and grievances. | Grievances and appeals P&P explains to the extent to which the ICDS Plan will assist an enrollee in filing an appeal or grievance. | |
| 508. The ICDS Plan maintains policies and procedures for enrollee grievances that include the following:<br>a. The ICDS Plan has a system for receiving and resolving internal grievances received from its enrollees;<br>b. The ICDS Plan will track and resolve grievances according to the Medicare and Medicaid rules; and<br>c. The ICDS Plan re-routes grievances to the coverage decision or appeals process when appropriate. | Grievances P&P include these specifications. | |
| 509. The ICDS Plan maintains the following timeframes for acceptance and resolution of enrollee appeals other than for Medicare Part D appeals:<br>a. The ICDS Plan will allow enrollees, authorized representatives of enrollees, and providers 90 days to file an appeal of the denial, reduction, suspension or termination of Medicare services;<br>b. The ICDS Plan will allow enrollees and authorized representatives of enrollees 90 days to file an appeal of the denial, reduction, suspension or termination of Medicaid services;<br>c. For standard appeals, the ICDS Plan will resolve standard appeals as expeditiously as the enrollee's condition requires and no later than 15 calendar days after the request; and<br>d. The ICDS Plan will resolve expedited appeals as expeditiously as the enrollee's condition requires and no later than 72 hours after the request. | Appeals P&P include these specifications. | |
| 510. The ICDS Plan maintains policies and procedures for Part D appeals that are consistent with current Part D requirements. | Part D appeals P&P includes these requirements for processing appeals. | |
| 511. The ICDS Plan maintains the following policies and procedures for enrollee appeals:<br>a. For Medicare service denials, reductions, suspensions and terminations, the request for the first level of appeal will be made to the ICDS Plan;<br>b. Any denials of Medicare services/items that are upheld on the initial first level of appeal will be automatically forwarded to the Independent Review Entity (IRE);<br>c. For Medicaid service denials, ICDS enrollees are permitted to access the ICDS Plan's internal appeal process concurrently with requesting a hearing with the Bureau of | Appeals P&P includes these requirements. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| State Hearings; and<br>d. When both the Bureau of State Hearings and the IRE issue rulings, the ICDS Plan will be bound by the decision that is most favorable to the enrollee. | | |
| 512. The ICDS Plan will continue a member's benefits when an appeal has been filed if the following conditions are met :<br>a. The enrollee or authorized representative files the appeal on or before the later of the following:<br>i. Within 15 business days of when the ICDS Plan mails the notice of action; or<br>ii. The effective date of the proposed action;<br>b. The appeal involves the termination, suspension, or reduction of services prior to the enrollee receiving the previously authorized course of treatment;<br>c. The services were ordered by an authorized provider;<br>d. The authorization period has not expired; and<br>e. The enrollee requests the continuation of benefits. | Appeals P&P confirm that any benefits or services being appealed through the internal appeals process are continued for the length of the appeal. | |
| 513. If the ICDS Plan continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:<br>a. The enrollee withdraws the appeal;<br>b. Fifteen calendar days pass following the ICDS Plan's notice to the enrollee of an adverse appeal decision unless the enrollee, within the fifteen-day timeframe, requests a state hearing with continuation of benefits;<br>c. A state hearing regarding the continuation of the benefits is decided adverse to the enrollee; or<br>d. The initial time period for the authorization expires or the authorization service limits are met. | Appeals P&P confirm that the Plan continues or reinstates the enrollee's benefits while the appeal is pending (until one of the enumerated events occurs). | |
| **Organizational Structure and Staffing** | | |
| **A. Organizational structure and staffing** | | |
| 701. The ICDS Plan has position of Administrator/CEO/COO that must be filled by an individual who:<br>a. Works in Ohio;<br>b. Works in a full time capacity (40 hours weekly) for the ICDS Plan;<br>c. Is available during ODM working hours to fulfill the responsibilities of the position | Position description provides evidence that the ICDS Plan has the specified position. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| and to oversee the entire operation of the ICDS Plan; and<br>d. Devotes sufficient time to the ICDS Plan's operations to ensure adherence to program requirements and timely responses to ODM. | | |
| 702. The ICDS Plan has a position of Medical Director/CMO that:<br>a. Works in Ohio;<br>b. Is filled by an individual who is a physician with a current, unencumbered license through the Ohio State Medical Board;<br>c. Has at least three (3) years of training in a medical specialty;<br>d. Devotes full time (minimum 32 hours weekly) to the ICDS Plan's operations to ensure timely medical decisions, including after-hours consultation as needed;<br>e. Is actively involved in all major clinical and quality management components of the ICDS Plan;<br>f. Is responsible, at a minimum, for the following functions:<br>g. Development, implementation and medical interpretation of medical policies and procedures including, but not limited to:<br>i. Service authorization;<br>ii. Claims review;<br>iii. Discharge planning;<br>iv. Credentialing;<br>v. Referral management; and<br>vi. Medical review included in the ICDS Plan Grievance System;<br>h. Administration of all medical management activities of the ICDS Plan; and<br>i. Serves as director of the Utilization Management committee and chairman or co-chairman of the Quality Assessment and Performance Improvement Committee. | Position description provides evidence that the ICDS Plan has the specified position. | |
| 703. The ICDS Plan has a position of Contract Compliance Officer that:<br>a. Works in Ohio;<br>b. Is filled by an individual who will serve as the primary point-of-contact for all ICDS Plan operational issues; and<br>c. Performs the following functions:<br>i. Overall communication between OMA and the ICDS Plan;<br>ii. Coordinating the tracking and submission of all contract deliverables;<br>iii. Fielding and coordinating responses to ODJFS inquiries;<br>iv. Coordinating the preparation; and<br>v. Execution of contract requirements, random and periodic audits and site | Position description provides evidence that the ICDS Plan has the specified position. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| visits. | | |
| 704. The ICDS Plan :<br>a. Hires Provider Services Representatives who are:<br>i. Based in Ohio; and<br>ii. Responsible for resolving provider issues, including, but not limited to problems with:<br>1. Claims payment;<br>2. Prior authorization, and<br>3. Provider appeals; and<br>b. Employs an adequate number of Provider Services Representatives to meet the needs of medical, behavioral, long-term services and supports providers in each service area. | Position description provides evidence that the ICDS Plan has the specified position. | |
| 705. The ICDS Plan has a position of Care Management Director that:<br>a. Works in Ohio;<br>b. Is filled by an individual who is an Ohio-licensed registered nurse, preferably with a designation as a Certified Case Manager (CCM) from the Commission for Case Manager Certification (CCMC);<br>c. Is responsible for overseeing the day-to-day operational activities of the Care Management Program in accordance with state guidelines;<br>d. Is responsible for ensuring the functioning of care management activities across the continuum of care, including but limited to:<br>i. Assessing;<br>ii. Planning;<br>iii. Implementing;<br>iv. Coordinating;<br>v. Monitoring; and evaluating<br>e. Has experience in the activities of care management as specified in 42 CFR §438.208;<br>f. Performs the following functions:<br>vi. Ensuring implementation of mechanisms for identifying, assessing, and developing a treatment plan for an individual with special health care needs;<br>vii. Ensuring access to primary care and coordination of health care services for all members; and | Position description provides evidence that the ICDS Plan has the specified position. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| viii. Ensuring the coordination of services furnished to the enrollee with the services the enrollee receives from any other health care entity. | | |
| 706. The ICDS Plan has a position of Quality Improvement Director that:<br>a. Works in Ohio;<br>b. Must be filled by an individual who is an Ohio-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and<br>Utilization Review Providers.<br>c. Must have experience in quality management and quality improvement as specified in 42 CFR §438.200 – 438.242; and performs the following functions:<br>i. Ensuring individual and systemic quality of care<br>ii. Integrating quality throughout the organization<br>iii. Implementing process improvement<br>iv. Resolving, tracking and trending quality of care grievances | Position description provides evidence that the ICDS Plan has the specified position. | |
| 707. The ICDS Plan has position of Long-Term Care Services and Supports/Home and Community-Based Services (LTCSS/HCBS) Director that:<br>a. Works in Ohio;<br>b. Is filled by an individual who is an Ohio licensed nurse, Licensed Independent Social Worker (LISW) or has a Master's degree in a health related field;<br>c. Has at least five years of experience in home and community based services;<br>d. Performs the following functions:<br>i. Implementation and oversight of all clinical management functions for individuals receiving LTCSS including but not limited to:<br>A. Assessment;<br>B. Service planning;<br>C. Care coordination;<br>D. Transition planning;<br>E. Consumer hearings; and<br>F. Participant and caregiver education and training;<br>ii. Implementation and oversight of all provider management functions for providers of HCBS services, including but not limited to:<br>A. Provider enrollment; | Position description provides evidence that the ICDS Plan has the specified position. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| B. Orientations and monitoring; and<br>C. Operation of an incident management, investigation and response system.<br>iii. Implementation and oversight of all program management functions, including but not limited to:<br>A. Compliance with program requirements, rules and regulations;<br>B. Implementation and management of program policies and procedures and protocols that are aligned with federal and state requirements:<br>C. Member complaint process; and<br>D. Community education. | | |
| 708. The ICDS Plan has position of Behavioral Health Director that is filled by an individual who:<br>a. Works in Ohio;<br>b. Possesses an independent license to provide behavioral health services in the State of Ohio (MD, DO, RN with Advanced Practice Certification, Psychologist, LISW, PCC, IMFT);<br>c. Has a minimum of five years' experience in the provision and supervision of treatment service for mental illness and substance use disorders;<br>d. Demonstrates knowledge and understanding of Ohio's overall behavioral health system which includes Mental Health, Alcohol and Drug Addiction, and Developmental Disabilities Services;<br>e. Is responsible for the daily operational activities of behavioral health services across the full spectrum of care to Medicare-Medicaid Enrollees, inclusive of mental health, substance abuse and developmental disabilities services;<br>f. Assures 24/7 availability of staff to assist in locating providers in a timely manner to provide prompt access to necessary levels of treatment to assure the health and safety of identified patients and the community, and have access to the Medical Director for consultation as needed;<br>g. Assures overall integration of behavioral health services in the ICDS Plan member's treatment plan;<br>h. Performs the following functions: | Position description provides evidence that the ICDS Plan has the specified position. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| v. Ensuring receipt of Behavioral Health Services including mental health, substance abuse and developmental disabilities services;<br>vi. Ensuring systematic screening for behavioral health related disorders by utilizing standardized and/or evidence-based approaches;<br>vii. Promoting preventive behavioral health strategies;<br>viii. Identifying and coordinating assistance for identified member needs specific to behavioral health;<br>ix. Interfacing with the Community Behavioral Health Center health homes for ICDS Plan members with Serious and Persistent Mental Illness and community partners; and<br>x. Participating in management and program improvement activities with the other key staff for enhanced integration and coordination of behavioral health services and achievement of outcomes. | | |
| 709. The ICDS Plan:<br>a. Establishes at least one consumer advisory committee;<br>b. Establishes a process for the consumer advisory committee to provide input to the governing board; and<br>c. Provides for the participation of enrollees with disabilities within the governance structure of the ICDS Plan. | Bylaws governing the ICDS Plan's consumer advisory committee state that consumers with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the ICDS Plan), and that the committee has a process for providing input to the ICDS Plan's governing board. | |
| **B: Sufficient Staff** | | |
| 710. The ICDS demonstrates that it has sufficient employees and/or contractor staff to perform care management activities (including waiver service coordination) through its staffing plan. The staffing plan must explain:<br>a. The ICDS plan's estimate of its enrollment over the enrollment period;<br>b. Which staff position(s) will complete the function;<br>c. How many employees in those position(s) the ICDS Plan believes will be needed to perform the function;<br>d. How the ICDS Plan will maintain the minimum staffing ratio requirements for each stratification level; and<br>e. In what timeframe the ICDS plan will staff to the level indicated. | The ICDS Plan has a staffing plan that shows how it has arrived at an estimated staffing ratio for care management activities (including waiver service coordination ) and in what timeframe it intends to staff to that ratio. | |
| 711. The ICDS Plan demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances through its staffing plan. | The ICDS Plan has a staffing plan that shows how it has arrived at an | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| The staffing plan must explain:<br>a. The ICDS Plan's estimate of its enrollment over the enrollment period;<br>b. Which staff position(s) will complete the function;<br>c. How many employees in those staff position(s) the ICDS Plan believes will be needed to perform the function;<br>d. How the ICDS Plan derived that estimate; and<br>e. In what timeframe the ICDS Plan will staff to the level indicated. | estimated staffing ratio for organization and coverage determinations and appeals and grievances, and in what timeframe it intends to staff to that ratio. | |
| 712. The ICDS Plan demonstrates that it has sufficient employees and/or contractor staff to handle the operations of its enrollee services telephone line, care management support line, and coverage determinations and appeals line, through its staffing plan. For each of these three telephone lines, the staffing plan must explain:<br>a. The ICDS Plan's estimate of its enrollment over the enrollment period;<br>b. Which staff position(s) will complete the function;<br>c. How many employees in those staff position(s) the ICDS Plan believes will be needed to perform the function;<br>d. How the ICDS Plan derived that estimate; and<br>e. In what timeframe the ICDS Plan will staff to the level indicated. | The ICDS Plan has a staffing plan that shows how it has arrived at an estimated staffing ratio for operations of its enrollee services telephone line, care management support line and coverage determinations and appeals line and in what timeframe it intends to staff to that ratio. | |
| 713. The ICDS Plan Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity. | Utilization management program description or coverage determination P&P includes requirement that medical director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.<br><br>Job description for the medical director includes this responsibility. | |
| **C: Staff Training** | | |
| 714. The ICDS Plan trains its staff in critical incident and abuse reporting, including ways to detect and report instances of abuse, neglect, and exploitation of enrollees by service providers and/or natural supports providers. | The ICDS Plan's P&Ps indicate that training materials will include training on critical incident and abuse (NOTE: actual training materials will be collected at a later date). | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| 715. The ICDS Plan conducts training for trans-disciplinary care management team members initially and on an annual basis on:<br>a. The person-centered planning processes;<br>b. Cultural competence;<br>c. Accessibility and accommodations;<br>d. Independent living and recovery;<br>e. ADA/Olmstead requirements; and<br>f. Wellness principles. | The ICDS Plan's P&Ps indicate that training materials for trans-disciplinary care management team members and potential trans-disciplinary care management team members will include the required topics (NOTE: actual training materials will be collected at a later date).<br>Care coordination P&P states that completion of training of trans-disciplinary care management team members will be documented and defines the consequences associated with non-completion of trans-disciplinary care management team trainings. | |
| 716. The ICDS Plan provides training on the following topics to all care managers and waiver service coordinators annually:<br>a. Abuse, neglect, and exploitation, and all other incident reporting;<br>b. Cultural competency/diversity training that is specific to the region and addresses the culture/diversity in that region;<br>c. Medication management;<br>d. Level of care;<br>e. Provider service specifications, including process for requesting home and vehicle modifications and adaptive and assistive equipment;<br>f. Risk and safety planning – identifying individual risks and the modifications or equipment necessary to maintain an individual in the home;<br>g. Individualized service planning and self-direction;<br>h. Restraints, seclusion, and restrictive interventions;<br>i. Community resources, including an overview of at least one other service delivery system (such as, Developmental Disabilities, Mental Health, Aging, Health, etc.) an explanation of the resources available, and training on how to access the services;<br>j. HIPAA; and<br>k. Customer service. | The ICDS Plan's P&Ps indicate that training materials will include the required topics (NOTE: actual training materials will be collected at a later date). | |
| 717. The ICDS Plan trains all staff who are expected to have contact with enrollees on enrollee | The ICDS Plan's P&Ps indicate that | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| protections, including the ICDS Plan's organization and coverage determination and appeals and grievance processes. | training materials will include the required enrollee protections topics (NOTE: actual training materials will be collected at a later date). | |
| 718. The ICDS Plan or PBM has scripts for its pharmacy customer service hotline staff including, but not limited to:<br>a. Best Available Evidence policy;<br>b. Request for pre-enrollment information;<br>c. Benefit information;<br>d. Cost-sharing information;<br>e. Continuity of care requirements;<br>f. Enrollment/disenrollment;<br>g. Formulary information;<br>h. Pharmacy information, including whether an enrollee's pharmacy is in the ICDS Plan's network;<br>i. Provider information, including whether an enrollee's physician is in the ICDS Plan's network;<br>j. Out-of-network coverage;<br>k. Claims submission, processing, and payment;<br>l. Formulary transition process;<br>m. Grievance, coverage determination, and appeals process (including how to address Medicaid drug appeals);<br>n. Information on extra help, including how the enrollee can obtain extra help;<br>o. Current TrOOP status;<br>p. Information on how to obtain needed forms;<br>q. Information on replacing an identification card; and<br>r. Service area information. | Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria. | |
| 719. The ICDS Plan ensures that enrollee services telephone line and pharmacy customer service hotline staff have been adequately trained in the following areas:<br>a. Explaining the operation of the ICDS Plan and the roles of participating providers;<br>b. Assisting enrollees in the selection of a primary care provider;<br>c. Assisting enrollees to obtain services and make appointments; and<br>d. Handling or directing enrollee inquiries or grievances. | Content from training programs or orientation modules demonstrates staff from the ICDS Plan trains its enrollee services telephone line staff and pharmacy customer service line personnel on these topics.<br><br>Step-by-step procedures or a flow | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| | chart showing how staff from the ICDS Plan would walk through assisting enrollees in explaining or selecting services. | |
| **Systems** | | |
| **A. Date Exchange** | | |
| 1101. The ICDS Plan is able to electronically exchange the following types of data:<br>a. Person Centered Individualized Care Plan<br>b. Enrollee benefit plan enrollment, disenrollment, and enrollment-related data;<br>c. Claims data (including paid, denied, and adjustment transactions);<br>d. Financial transaction data (including Medicare C, D, and Medicaid payments);<br>e. Third-party coverage data;<br>f. Provider data;<br>g. Prescription drug event (PDE) data;<br>h. Health information from provider electronic medical record systems. | Baseline documentation should illustrate examples of the listed data transmission types and the policies and procedures for securing, processing and validating the data exchange | |
| 1102. The ICDS Plan or its contracted pharmacy benefits manager (PBM) is able to exchange Part D data with the TrOOP Facilitator. | Baseline documentation should include a data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator. Supporting documentation should include transaction facilitator certification documentation for its FIR. | |
| 1103. The ICDS Plan ensures that health information technologies and related processes support national, state and regional standards for health information exchange and interoperability. | Baseline documentation should include policies and procedures for monitoring the standards for health information exchange and interoperability. The ICDS Plan should highlight any HIE networks they currently participate in or are preparing to participate in. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| **B: Data Security** | | |
| 1104. The ICDS Plan has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident. | Baseline documentation should include a copy of the ICDS Plan's disaster recovery and business continuity plan and an inventory of the core systems specifically used to operate this Demonstration. Supplemental documentation may include proof of disaster recovery plan validation and testing. | |
| 1105. The ICDS Plan facilitates the secure, effective transmission of data. | Baseline documentation should include:<br>1. The ICDS Plan's Data Security and Privacy P&P; and<br>2. The ICDS Plan's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives.<br>3. Documentation of processes to document a breach in data integrity and any associated corrective actions. | |
| 1106. The ICDS Plan maintains a history of changes, adjustments, and audit trails for current and past data systems. | Baseline documentation should include Change Management P&Ps. | |
| 1107. The ICDS Plan complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (standard unique health identifier for health care providers). | Baseline documentation should include:<br>1. ICDS Plan P&P noting compliance with NPI standards, specifications, and requirements.<br>2. Screenshot of provider data/records illustrating that the NPI data field is populated in the provider system. | |
| **C. Enrollment Systems** | | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| 1108. The ICDS Plan receives, processes, and reconciles in an accurate and timely manner:<br>a. The CMS Daily Transaction Reply Report (DTRR) from the CMS designated enrollment vendor; and<br>b. The benefit and enrollment maintenance file from the state (HIPAA 834 transaction). | Baseline documentation should include the ICDS Plan's P&P on processing and reconciling enrollment files.<br><br>Documentation should also include the ICDS Plan's enrollment systems schematic that details the daily enrollment processing capacity. | |
| 1109. If the ICDS Plan receives a CMS DTRR with confirmation of a successfully processed enrollment transaction, the ICDS Plan submits a 4Rx transaction (TC 72) to CMS' enrollment vendor within 72 hours of receipt of the DTRR. The 4Rx data elements are:<br>a. RxBIN – Benefit Identification Number;<br>b. RxPCN – Processor Control Number;<br>c. RxID – Identification Number; and<br>d. RxGRP – Group Number. | Baseline documentation should include the ICDS Plan's P&P for creating and submitting 4Rx transaction files. Additional information should include data specifications detailing the listed data elements. | |
| 1110. The ICDS Plan's enrollment/member system includes each of the following data elements:<br>a. Name;<br>b. Date of birth;<br>c. Gender;<br>d. Telephone #;<br>e. Permanent residence address;<br>f. Mailing address;<br>g. Medicare #;<br>h. ESRD status;<br>i. Other insurance COB information;<br>j. Language preference and alternative formats;<br>k. Enrollee signature and/or authorized representative signature;<br>l. Date of signature;<br>m. Authorized representative contact information;<br>n. Information provided under "please read and sign below"<br>o. Release of information;<br>p. Option to request materials in a language other than English or in alternate formats; and<br>q. Medicaid #. | Documentation should include screenshots of the ICDS Plan's enrollment/member system that confirms each data element listed is available in the system. | |
| **D. Claims Processing** | | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| 1111. The ICDS Plan processes accurate, timely, and HIPAA-compliant claims and adjustments and calculates adjudication processing rates. This includes a process and timeframe for managing pended claims. | Baseline documentation should include:<br>1. Claims processing P&P that details claims processing turnaround timeframes, steps for managing pended claims, including turnaround times, and methods for ensuring claims processing accuracy.<br>2. Claims processing statistics (e.g. average daily/monthly claims processed, pended and denied, percent paper, etc.). | |
| 1112. The ICDS Plan processes adjustments and issues refunds or recovery notices within 45 days of receipt of complete information regarding a retroactive medical and community-based or facility-based LTSS claims adjustment. | Baseline documentation should include P&Ps on claims adjustments, refunds and recoveries that specify a 45-day processing requirement for retroactive medical and community-based and facility-based LTSS claims. | |
| 1113. The claims systems have the capacity to process the volume of claims anticipated under the Demonstration. | Baseline documentation should include load and performance testing, current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the Demonstration. Documentation should highlight the basis for ICDS Plan's estimates as well as highlight mitigation procedures for addressing the large percentage increase in claims volume by ICDS Plan staff without affecting performance standards.<br>Supplemental documentation may include statistics on average claims | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| | processed per processor, annual average of claims per Participant (with current plans), aging for pended claims, and other metrics used to monitor and evaluate claims processing performance and capacity. | |
| 1114. The claims system fee schedule includes all medical, community –based and facility-based LTSS, home and community –based services (HCBS), Medicare and Medicaid services. | Baseline documentation should illustrate the following:<br>1. The ICDS Plan's process and plan for loading and validating the Demonstration fee schedules.<br>2. Screenshots of the modules where the fee schedules will be configured and identify how medical, community-based and facility-based LTSS and HCBS Medicare, and Medicaid services are captured within the system. | |
| 1115. The claims processing system properly adjudicates claims for Medicare Part D and Medicaid prescription and Medicaid over- the counter drugs. | Baseline documentation should include:<br>1. The ICDS Plan's oversight procedures for monitoring pharmacy claims processing including the PBM's plan to configure, test, and implement the benefits and adjudication rules to properly process Medicare Part D and Medicaid prescription and Medicaid over-the-counter drugs for the Demonstration.<br>2. The PBM's P&P and/or project plan for loading and validating benefit plans (e.g., formularies, system edits for transition period | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| | processing) for prescription and over-the-counter drugs.<br>3. Adjudication workflows that show coordination of Medicare and Medicaid formularies for accurate processing of all prescriptions and over-the-counter drugs. | |
| 1116. The ICDS Plan has an appropriate financial management system for self-direction budgets. | The ICDS Plan can document that it will contract with the State's FMS vendor. | |
| **E: Claims Payment** | | |
| 1117. 1. Except when a mutual agreement in accordance with 42 CFR 447.46 (b)(2)applies, the ICDS Plan pays:<br>a. 90% of "clean" medical and LTSS (community-based and facility-based LTSS claims) within 30 days of receipt; and.<br>b. 99% of "clean" medical and LTSS (community-based and facility-based LTSS claims) within 90 days of receipt. | Baseline documentation should include:<br>1. Claims P&P that describes clean claims payment requirements and standards.<br>2. Claims payment report sample that details the average number of days between receipt and payment of current clean claims. | |
| 1118. The ICDS Plan's PBM pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within 14 days of receipt for electronic claims and within 30 days of receipt all other claims. The ICDS Plan's PBM pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims), except in exigent circumstances such as a natural disaster that prevent the timely processing of claims. | Baseline documentation should include:<br>1. The ICDS Plan's PBM's claims P&Ps that describe clean claims payment standards.<br>2. The ICDS Plan's PBM's P&Ps that define distinct interest payment requirements for clean electronic and all other claims. | |
| 1119. The ICDS Plan's PBM assures that pharmacies located in, or having a contract with, a long-term care facility must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement. | Baseline documentation should include ICDS Plan's PBM's pharmacy network provider P&Ps that detail the timeframe for submission of ICDS Plan sponsor claims from long term care | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| | facilities. | |
| 1120. The ICDS Plan's claims processing system checks claims payment logic to identify erroneous payments. | Baseline documentation should include a description of system edits as well as proscriptive and retrospective reporting to identify claims processing trends and anomalies used to identify erroneous claims.<br>Note: If this validation is performed outside of the ICDS Plan, please provide evidence of the contract with the external vendor, as well as oversight P&Ps, and any performance standards. | |
| 1121. The ICDS Plan's claims processing system checks for pricing errors to identify erroneous payments. | Baseline documentation should include a description of system edits as well as ongoing reporting to identify pricing errors to prevent erroneous payments. The ICDS Plan should provide a listing of all audit processes in place to ensure the integrity of the claims processing payments including both automated and manual audits.<br>Note: If this validation is performed outside of the ICDS Plan, please provide evidence of the contract with the external vendor, as well as oversight P&Ps. | |
| **F: Provider Systems** | | |
| 1122. The system generates and maintains records on medical provider and facility networks, including but not limited to:<br>a. Provider name;<br>b. Provider address;<br>c. Provider phone number; | Baseline documentation should include a description of the system utilized to maintain the core provider system record along with provider system screen shots illustrating where | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| d. Provider type;<br>e. Licensing information;<br>f. Hospital/Facility Affiliation;<br>g. Office hours;<br>h. Language capability;<br>i. Medical specialty, for clinicians;<br>j. Whether the provider is accepting new members; and<br>k. ADA - Accessibility of provider office. | these data elements are captured.<br><br>Note: if all the required fields aren't currently captured in the provider system data fields, provide an explanation of what changes need to be made to the system and the timing for these modifications.<br>The information captured here will in turn be used to populate the printed and internet versions of the provider directory. | |
| 1123. The Provider System must be equipped to utilize the File Specifications and interact with the Managed Care Provider Network (MCPN). | File specification document for the MCPN should be what all ICDS Plans utilize in submitting provider information as indicated above to the state. | |
| **G: Pharmacy Systems** | | |
| 1124. The ICDS Plan generates and maintains or ensures that its PBM generates and maintains records on the pharmacy networks, including locations and operating hours where the ICDS Plan subcontracts the maintenance of the pharmacy network. | Baseline documentation should include:<br>1) ICDS Plan's PBM's P&Ps for maintaining records on pharmacy networks including locations and operating hours.<br>2) A screenshot or sample of how this information is collected, maintained, and made accessible to Participants. | |
| 1125. The ICDS Plan's PBM updates records of pharmacy providers and deletes records for pharmacies that are no longer participating. ICDS Plan ensures that the PBM performs this function in those instances where the ICDS Plan subcontracts the maintenance of the pharmacy network. | Baseline documentation should include the ICDS Plan's P&P and as applicable the PBM's P&P for updating/maintaining pharmacy provider network information. | |
| 1126. The ICDS Plan audits the pharmacy system on a regular basis. This includes auditing the pharmacy system of its PBM on a regular basis in those instances where the ICDS Plan subcontracts | Baseline documentation should include the ICDS Plan's P&P for | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
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| the maintenance of the pharmacy network. | oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring. | |
| 1127. The ICDS Plan's PBM can submit Prescription Drug Event data (PDEs) on a monthly basis. | Baseline documentation should include:<br>1. ICDS Plan or its PBM's P&P that defines the processes and data submission requirements for Part D PDE reporting.<br><br>2. ICDS Plan's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting. | |
| 1128. The ICDS Plan's PBM is prepared to ensure pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid-covered drugs and secondary payers can properly coordinate benefits by utilizing unique routing identifiers and Participant identifiers. | Baseline documentation should include the ICDS Plan and its PBM's P&Ps and related workflows for determining appropriate claims payment for Part D covered drugs, Medicaid-covered drugs and can be properly coordinated with secondary payers. | |
| 1129. The ICDS Plan ensures that the PBM's claims adjudication system:<br>a. Distinguishes between filling prescriptions for Part D drugs and non-Part D drugs;<br>b. Appropriately meets the 90-day Part D transitional fill requirements; and<br>c. Makes appropriate outreach efforts related to the transitional fills;<br>d. Provides an integrated formulary to include any Medicaid-covered drugs that are excluded Medicare Part D. | Baseline documentation should include:<br>1. The ICDS Plan's PBM's P&Ps for supporting the transitional fill requirements.<br>2. Evidence of systems capability to support both Part D and non-Part D formularies and transitional fill requirements.<br>3. The ICDS Plan's P&P for oversight of the PBM performance on transitional fills. | |
| 1130. The Plan's PBM has a disaster recovery and business continuity plan to ensure that | Baseline documentation should | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| contracted pharmacies can determine drugs that are covered under the Demonstration and ensure continuity of care and access to medication for the Demonstration enrollees in the event the PBM systems are inaccessible. | include information about the PBM's disaster recovery and business continuity plan for confirming enrollee benefit coverage, ensuring that contracted pharmacies are able to determine what drugs are covered under the Demonstration, and that enrollees receive their required medications. | |
| **H: Care Management System** | | |
| 1131. The system generates and maintains records necessary for care management, including:<br>a. Enrollee data (from the enrollment system);<br>b. Provider network;<br>c. Trans-disciplinary care team membership for specific enrollees;<br>d. Enrollee assessments including tracking of risk status;<br>e. Enrollee plans of care, including goals, interventions, outcomes and completion dates;<br>f. Trans-disciplinary care team case notes;<br>g. Enrollee and provider contact notes;<br>h. Claims information;<br>i. Pharmacy data;<br>j. Waiver Service Coordinator; and<br>k. Waiver Service Plan Indicator. | Baseline documentation should illustrate where each of these items are captured in the care coordination system. If screenshots are provided, note where each item is captured. If the system requires modifications to support new data fields, provide information that details the requirements and timeline for these system modifications. | |
| 1132. The ICDS Plan maintains the care management system and addresses technological issues immediately as they arise to ensure appropriate information is readily available for care coordination. | Baseline documentation should include the ICDS Plan's P&P for ensuring data quality in the care coordination system. | |
| 1133. The ICDS Plan verifies the accuracy of care management data and amends or corrects inaccuracies. | Baseline documentation should include the ICDS Plan's P&P for ensuring data quality in the care coordination system.<br>Specifications should describe automated processes for finding data anomalies and describe processes for manually overwriting data in the instance of an error. | |

| Criteria | Example Evidence | File/Document Name and Page Numbers/Sections |
|---|---|---|
| 1134. The enrollee assessments and plans of care are available to the enrollee, the enrollee's trans-disciplinary care management team and any of the enrollee's other providers, upon request. | Documentation should include:<br>1. The ICDS Plan's P&P for securing and providing access to the care coordination system.<br>2. The ICDS Plan's workflow processes for making enrollee assessment and plans of care information available to the enrollee's providers. | |
| 1135. The care management system includes a mechanism to alert the care manager of ED use or inpatient admissions. | Specifications and manual describe alert system to notify trans-disciplinary care management team members when an enrollee ends up in the hospital. | |